

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_ REFERRED BY \_\_\_\_\_

Your Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Your Cardiologist \_\_\_\_\_ Phone # \_\_\_\_\_

**BRIEFLY DESCRIBE REASON FOR YOUR VISIT**

**Medical History**

- |                           |                          |                          |
|---------------------------|--------------------------|--------------------------|
|                           | yes                      | no                       |
| diabetes                  | <input type="checkbox"/> | <input type="checkbox"/> |
| high blood pressure       | <input type="checkbox"/> | <input type="checkbox"/> |
| sleep apnea (c-pap)       | <input type="checkbox"/> | <input type="checkbox"/> |
| seizures                  | <input type="checkbox"/> | <input type="checkbox"/> |
| pneumonia                 | <input type="checkbox"/> | <input type="checkbox"/> |
| asthma                    | <input type="checkbox"/> | <input type="checkbox"/> |
| tuberculosis              | <input type="checkbox"/> | <input type="checkbox"/> |
| emphysema                 | <input type="checkbox"/> | <input type="checkbox"/> |
| kidney disease            | <input type="checkbox"/> | <input type="checkbox"/> |
| hepatitis                 | <input type="checkbox"/> | <input type="checkbox"/> |
| liver disease             | <input type="checkbox"/> | <input type="checkbox"/> |
| stomach ulcers            | <input type="checkbox"/> | <input type="checkbox"/> |
| arthritis                 | <input type="checkbox"/> | <input type="checkbox"/> |
| gout                      | <input type="checkbox"/> | <input type="checkbox"/> |
| anemia                    | <input type="checkbox"/> | <input type="checkbox"/> |
| thyroid                   | <input type="checkbox"/> | <input type="checkbox"/> |
| phlebitis                 | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV                       | <input type="checkbox"/> | <input type="checkbox"/> |
| diverticulitis            | <input type="checkbox"/> | <input type="checkbox"/> |
| colon cancer              | <input type="checkbox"/> | <input type="checkbox"/> |
| gyn cancer - site _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| melanoma - site _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| other cancer - site _____ | <input type="checkbox"/> | <input type="checkbox"/> |

**Any other information you feel may be important to the doctor** \_\_\_\_\_

**Surgical History**

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
|                         | yes                      | no                       |
| gallbladder             | <input type="checkbox"/> | <input type="checkbox"/> |
| appendectomy            | <input type="checkbox"/> | <input type="checkbox"/> |
| hernia repair           | <input type="checkbox"/> | <input type="checkbox"/> |
| hemorrhoidectomy        | <input type="checkbox"/> | <input type="checkbox"/> |
| colon surgery           | <input type="checkbox"/> | <input type="checkbox"/> |
| orthopedic surgery      | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, body part _____ |                          |                          |
| Titanium or Metal       |                          |                          |
| Other surgery _____     |                          |                          |

**Cardiac History**

- |                     |                          |                          |       |
|---------------------|--------------------------|--------------------------|-------|
|                     | yes                      | no                       | year  |
| cardiac surgery     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| type _____          |                          |                          | _____ |
| pacemaker           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| defibrillator       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| stents              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| heart attack        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| heart valve disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| irregular heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| stroke              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

**Social History**

- |                       |                          |                          |                |
|-----------------------|--------------------------|--------------------------|----------------|
|                       | yes                      | no                       | If yes, amount |
| cigarette smoking     | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| cigar or pipe smoking | <input type="checkbox"/> | <input type="checkbox"/> | _____          |
| alcohol use           | <input type="checkbox"/> | <input type="checkbox"/> | _____          |

**Female Patients please answer the following:**

- Date of last menstrual period \_\_\_\_\_
- Date of last breast exam by a physician \_\_\_\_\_
- Date of last mammogram \_\_\_\_\_
- Age of first menstrual period \_\_\_\_\_

- |                                   |                          |                          |
|-----------------------------------|--------------------------|--------------------------|
|                                   | yes                      | no                       |
| Personal history of breast cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous breast surgery:          | <input type="checkbox"/> | <input type="checkbox"/> |
| biopsy                            | <input type="checkbox"/> | <input type="checkbox"/> |
| lumpectomy                        | <input type="checkbox"/> | <input type="checkbox"/> |
| mastectomy                        | <input type="checkbox"/> | <input type="checkbox"/> |
| implants                          | <input type="checkbox"/> | <input type="checkbox"/> |
| other _____                       |                          |                          |

**Family History**

- |                |                          |                          |          |
|----------------|--------------------------|--------------------------|----------|
|                | yes                      | no                       | Relative |
| diabetes       | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| heart disease  | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| colon cancer   | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| ovarian cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| breast cancer  | <input type="checkbox"/> | <input type="checkbox"/> | _____    |
| other _____    |                          |                          | _____    |

**Please check yes or no for each of the following if you have experienced within the last 2 months**

- |                         |                          |                          |                      |                          |                          |               |                          |                          |
|-------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|
|                         | yes                      | no                       |                      | yes                      | no                       |               | yes                      | no                       |
| unexplained weight loss | <input type="checkbox"/> | <input type="checkbox"/> | chest pain           | <input type="checkbox"/> | <input type="checkbox"/> | excessive gas | <input type="checkbox"/> | <input type="checkbox"/> |
| change in a skin lesion | <input type="checkbox"/> | <input type="checkbox"/> | ankle swelling       | <input type="checkbox"/> | <input type="checkbox"/> | hemorrhoids   | <input type="checkbox"/> | <input type="checkbox"/> |
| persistent headache     | <input type="checkbox"/> | <input type="checkbox"/> | palpitations         | <input type="checkbox"/> | <input type="checkbox"/> | indigestion   | <input type="checkbox"/> | <input type="checkbox"/> |
| nosebleeds              | <input type="checkbox"/> | <input type="checkbox"/> | difficulty urinating | <input type="checkbox"/> | <input type="checkbox"/> | jaundice      | <input type="checkbox"/> | <input type="checkbox"/> |
| neck pain               | <input type="checkbox"/> | <input type="checkbox"/> | blood in urine       | <input type="checkbox"/> | <input type="checkbox"/> | nausea        | <input type="checkbox"/> | <input type="checkbox"/> |
| chronic cough           | <input type="checkbox"/> | <input type="checkbox"/> | black or tarry stool | <input type="checkbox"/> | <input type="checkbox"/> | vomiting      | <input type="checkbox"/> | <input type="checkbox"/> |
| wheezing                | <input type="checkbox"/> | <input type="checkbox"/> | blood in stool       | <input type="checkbox"/> | <input type="checkbox"/> | dizziness     | <input type="checkbox"/> | <input type="checkbox"/> |
| breast mass             | <input type="checkbox"/> | <input type="checkbox"/> | constipation         | <input type="checkbox"/> | <input type="checkbox"/> | easy bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| nipple discharge        | <input type="checkbox"/> | <input type="checkbox"/> | diarrhea             | <input type="checkbox"/> | <input type="checkbox"/> | back pain     | <input type="checkbox"/> | <input type="checkbox"/> |

- Immunizations up to date? yes  no
- Pneumovax? yes  no  date \_\_\_\_\_
- Colonoscopy last 5 years yes  no
- Foreign travel within last year? yes  no
- Pregnancy History / number of pregnancies \_\_\_\_\_
- number of live births \_\_\_\_\_